Version: October 2014

Wyoming Breast & Cervical Cancer Early Detection Program
Women's Health Source

Wyoming Department of Health

Mail completed form to:
Wyoming Breast and Cervical Cancer Early Detection Program
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
1-800-264-1296 (phone)
Fax 1-307-777-3765
Web address: www.health.wyo.gov/PHSD/bccedp

Insurance: Do you have health insurance? ❒ Yes ❒ No
Do you have Medicaid (Title 19)? ❒ Yes ❒ No
Do you have Medicare Part B? ❒ Yes ❒ No

Personal Information

First Name: _____
Middle Initial: _____
Last Name: _____
Maiden Name: _____
Date of Birth: _____ Age: _____
Address: _____
City: _____ Zip: _____
Mailing Address: (if different than above)
_____
City: _____ Zip: _____
County: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Social Security Number: _____
(optional)

Office Use Only

Approved Initials: _____ _____ _____
Denied Initials: _____ _____ _____ _____
Date: _____
State ID #: _____

Staff Notes: _____
_____
_____
_____
_____

Risk Factors - *Circle responses.*

1. Do you currently smoke/use tobacco products? ***Yes*** ***No***
2. Have you had a hysterectomy? ***Yes*** ***No***
   If so, was your cervix removed?
   Yes ***No*** ***Don't Know***
3. When was your last Pap test? _____
   Was it abnormal? ***Yes*** ***No***
   **If yes, see instructions below for required report.
4. When was your last mammogram? _____
5. Was it abnormal? ***Yes*** ***No***
   **If yes, see instructions below for required report.
6. When was your last clinical breast exam?
   _____
7. Was it abnormal? ***Yes*** ***No***
   **If yes, see instructions below for required report.
8. Have you had breast cancer? ***Yes*** ***No***
   If yes, when? _____

Current Income: (List gross before taxes.)

Your current monthly household income:
_____
Number of people in household supported by this income: _____
Note: If your income varies from month to month, average the last three months.

****If you have had an abnormal clinical breast exam, Pap test and/or mammogram within the last three months, please request a copy of the report from your healthcare provider and mail or fax the report in with your application. If the report is not included, processing of your application will be delayed.**

How did you first learn about us? Please circle.

Healthcare Provider: Name of Provider: _____
Hospital ● Radio ● TV ● Newspaper ● Internet ● Friend ● Family Member ● Health Fair ● Women Wellness /Migrant Health ● Regional WY Cancer Resource Services ● Native American Program ● County Public Health Office ● Other : _____

Race/Ethnicity

Are you Hispanic or Latino?
❒ Yes ❒ No

Check one or more:
❒ White
❒ Black or African American
❒ American Indian, Alaska Native
❒ Asian
❒ Native Hawaiian or Other Pacific Islander
❒ Other: _____

Your Health Care Provider (if applicable)

Clinic Name:_____
Address: _____
City: _____ Zip: _____
Phone Number: _____

Alternate Contact ~ *Someone who does not live with you.*

Name: _____
Street Address: _____
City: _____ Zip: _____
Day Phone: _____
Relationship: _____

Consent, Release, & Confidentially Statement

The information I have provided is accurate to the best of my knowledge. I understand that if I am accepted into this program, and I have knowingly provided false information, I may be required to repay any benefits I have received. I understand that I could be prosecuted for fraud if: (a) I have provided false information and/or (b) any changes to my income and/ or insurance status are not reported after I am enrolled.

By agreeing to take part in this program, I give my permission to healthcare providers, billing agencies, Wyoming Department of Health, Wyoming Breast and Cervical Cancer Early Detection Program, the Centers for Disease Control and Prevention, and others involved in my care to share medical information obtained for the purpose of screening, diagnosis, treatment, and program evaluation.

I understand that information received by the Wyoming Breast and Cervical Cancer Early Detection Program will be treated as confidential and that any uses and disclosures will be in accordance with Wyoming Department of Health (WDH) policies.

For additional information regarding WDH uses and disclosures of protected health information, visit the Department's HIPAA website at http:// www.health.wyo.gov/main/hipaa.html or call (307) 777-8664.

Your consent is indicated by your signature below.

Sign Name: _____

Print Name: _____

Today's Date: _____ _____ _____ (mm/dd/yyyy)

If you or someone you know is interested in a free colonoscopy, call 1-866-205-5292

This form must be submitted within 30 days of your signature above. Please take the time to review this form, be sure all questions are answered, you have signed it, and have enclosed any required reports. Incomplete applications can not be processed. ***If you need help completing this form call 1-800-264-1296 and press Option # 1 for assistance.*** Form may be faxed to us to expedite process (fax:307-777-3765). *Thank you!*